Salford
Safeguarding
Children Partnership

Practice Review Policy and Procedure

February 2025

1. About this Policy and Procedure:

This is a multi-agency policy and procedure meaning that it applies to all organisations in Salford. It will navigate you through the process of a practice review. It applies to any professional or organisation involved in any aspect of the practice review process, from referral, right through to the review and embedding recommendations and actions into practice.

Our local process has been informed by the National Child Safeguarding Practice Review Panel guidance for safeguarding partners (September, 2022).

2. Principles, Values and Assumptions:

Our Multi Agency Safeguarding Arrangements outline how our vision, values and principles drive our approach. Practice reviews should reflect the following principles, values and assumptions:

2.1. Principles:

- Child and family centred: The individual (where able) and their families should be invited to contribute to reviews. They should understand how they are going to be involved, and their expectations should be managed appropriately and sensitively

- The framework must result in providing learning back into the system – its core purpose is to improve service provision not simply describe or challenge it

- There should be a culture of continuous learning and improvement across agencies that work together to safeguard and promote the wellbeing of children, identifying opportunities to draw on what works and promote good practice

- We support the principle of identifying issues and addressing them early, and individual agencies should be pro-active and pre-emptive in analysing and learning from individual cases. The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined

- The Safeguarding Children Partnership is responsible for the review and must assure themselves that it takes place in a timely manner and that appropriate action is taken to secure improvements in practice

- Any reviews should be led by individuals who are independent (i.e. no direct line management) of the case under review and of the organisations whose actions are being reviewed

- All types of practice reviews should be completed in a timely manner unless there is a reason for a longer period, e.g. on-going criminal proceedings.

2.2. Values and Behaviours:

- Participative and collaborative – Staff from all levels should participate and feel they are making a difference, and a consultative approach provides richer narrative, encourages awareness of quality issues and ownership of the findings. It encourages the view that measuring quality and impact is something done with and by staff rather than done to them. We include the voice and experience of families, children and young people wherever possible

- Transparent – delivering clear messages about the purpose of performance and quality assurance activity, with honest constructive feedback regarding how these benefit the organisation and

individuals. The aim is to encourage openness and engagement with the process and achieving goals

- Strengths Based: High challenge, high support - we are committed to a culture of improvement and learning which is relationship based and focuses on strengths within agencies, individuals, families and communities. It is a culture which delivers high levels of challenge and high levels of support, and we expect this to underpin our performance and quality assurance framework

- Outcome Focussed: consistently focussing on the lived experiences of children and the impact of what we do on outcomes for them

- Respectful: Each child and family's record belong to them. We must demonstrate our respect in the way we share and record information and provide feedback to staff. We have a duty to report with accuracy, and inaccurate recording of information in any form is detrimental to outcomes for children and families.

2.3. Assumptions:

- We can't always prevent children from being harmed, but we can always learn to increase our ability to achieve this. We will never be perfect, and constant scrutiny is required to ensure the right standards are met and exceeded and continuous improvement is evident across the system

- Professionals generally act from good intentions and try to act in the best interests of their clients. Organisations' systems, process, culture and other factors can lead to poor decision making and practice and these elements should also be the focus for review and improvement. For example, out-dated or unclear procedures, resources not available where needed

- Where possible, information relating to children and families will be based on reports drawn from case management systems and we expect individual agencies to ensure this remains accurate and relevant, with appropriate controls.

- Every agency has a responsibility for identifying and implementing its own learning in addition to multi-agency learning.

- Measures of outcomes for children are clearly the most important ones to assess, measuring the effectiveness of the system also requires a focus on both what we do and the impact of what we do in improving outcomes.

3. When to make a referral to the SSCP for a Practice Review:

A referral **must** be made to the SSCP in the event of a child death, or a child suffering serious harm where abuse, and/ or neglect are suspected (as detailed in Working Together to Safeguard Children, 2023). Our local model also allows for reviews of cases that may not meet the statutory criteria.

A referral may be made to the SSCP for consideration of a practice review to establish whether there are lessons to be learned about the way in which local professionals and organisations work together to safeguard and promote the welfare of children. Referrals may also be made to the SSCP for consideration of a Serious Offence Review where a child has been charged with a serious offence.

Referrals can be made to the SSCP to highlight a seriously good outcome for a child or their family, where multi agency safeguarding practice has been particularly effective.

The referral form can be accessed within the toolkit.

4. Purpose of Reviews:

The purpose of any review of practice is to identify improvements to be made to safeguard and promote the welfare of children. The purpose of a review is to:

- understand what happened or is happening, and why
- highlight any lessons that can be learned from the case and make a clear set of recommendations and ensure relevant action is taken
- learn lessons from the way professionals and agencies worked together and improve future practice by implementing the learning
- identify what the agencies and individuals might have done differently that could have prevented harm or death
- prevent similar harm occurring in the future
- review and improve relevant procedures
- identify good practice.

Reviews should focus more on understanding whether there are systemic issues and whether and how policy and practice need to change, than holding individuals, organisations or agencies to account. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy makers.

5. Practice Reviews in Salford:

5.1. Rapid Review

Safeguarding partners are required to promptly undertake a rapid review on all notified serious incidents. Rapid Reviews should be submitted to the National Child Safeguarding Practice Review Panel within 15 working days of notification by the Local Authority. Rapid reviews should identify, collate, and reflect on the facts of the case as quickly as possible to establish whether there is any immediate action needed to ensure a child's safety and the potential for practice learning. Further information about the Rapid Review Process is detailed within the Child Safeguarding Practice Review Panel guidance for safeguarding partners (September 2022) and Practice Review Referral Pathway guidance.

5.2. Local Child Safeguarding Practice Review

The overall purpose of a LCSPR is to identify improvements to local practice and wider systems through the identification of new learning that is not yet available in the local safeguarding systems, or to tackle perennial problems that need further or perhaps different attention. More information is available in the Practice Review Referral Pathway guidance document.

5.3. Serious Offence Reviews

Salford Safeguarding Children Partnership have agreed to use a local multi-agency review process when a serious offence involving a young person has taken place but does not meet the criteria for a Rapid Review or Child Safeguarding Practice Review. Please see Serious Offence Review Pathway for further details and how to make a referral. You can also access the relevant document below:

Serious incidents notification: standard operating procedures for youth justice services in England and Wales

5.4. Good Outcome Review

Referrals for a "Good Outcome Review" could be made in instances where there has been exceptionally positive impact on the lived experiences of the child, and good (better than normal) outcomes achieved. Good outcome reviews will examine multi agency success, how it was achieved and what we can learn to disseminate the success further. Sharing good practice and learning through a good practice review can help others drive change and improve the lives of children and their families.

Referrals should be very clear about what was done, and how this made a difference, and include the following features:

- The lived experience of the child and family- how we know we made a positive difference to their lived experience (outcomes).
- Present the steps you took to improve care in a practical and accessible way
- Give others the knowledge they need to improve care in their areas
- Provide an opportunity to reflect on your successes and challenges
- Help to identify learning and further areas for improvement
- Highlight learning that could be useful to others
- Be written in easy-to-understand English, free from jargon
- Have clear objectives, including an explanation of what was happening before the project, why it was needed and how it was implemented
- Outline any barriers the organisation faced when implementing the project and the methods used to overcome these
- Outline the effect the change had on service performance and outcomes through an evaluation process.

5.5. Non-Statutory Practice Review

The SSCP screening panel may determine that there are lessons to be learned from incidents that do not meet the criteria for a Serious Incident Notification (statutory review). In such circumstances a non-statutory review process may be recommended. More information is available in the Practice Review Referral Pathway guidance document.

5.6. Notification of the death of a care leaver

From January 2024, Local Authorities should notify the Secretary of State for Education and OFSTED of the death of a care leaver aged up to their 25th birthday as per the revisions to Working Together to Safeguard Children statutory guidance. Notifications for care leaver deaths will allow the Department for Education to understand and learn more about what happened so that we can make better informed policy decisions to prevent further deaths. In such circumstances, referrals should be made to the SSAB for consideration of a Safeguarding Adults Review (SAR).

6. What a Review is not

- The purpose of a statutory review is **not to hold any individual or organisation to account or to attribute blame**. Other processes exist for that, including criminal proceedings, disciplinary procedures, managing allegations against staff procedures, employment law and systems of service and professional regulation, such as Social Work England, Care Quality Commission (CQC) and the Nursing and Midwifery Council (NMC), the Health and Care Professions Council (HCPC), and the General Medical Council (GMC)

- A statutory review is also not a forum to complain or whistle blow about service provision which should be subject to the relevant agency's complaints process or appropriate whistleblowing procedures. If impacting safeguarding practice, then application of the SSCPs Professional Challenge and Escalation policy should be considered.

7. Other Learning Processes

- Dependent on the nature of the serious incident, a Child Safeguarding Practice Review may be running concurrently or even jointly with other defined learning processes including (but not exclusive to):

    - Safeguarding Adult Review
    - NHS Patient Safety Incident Response Framework
    - Independent Office of Police Conduct
    - Probation Serious Further Offence Reviews
    - Mental Health Homicide Review
    - MAPPA Serious Case Review
    - Domestic Abuse Related Death Review

  Updates and an overview of these processes will be discussed in CSPR Panel meetings with the expectation that connected agencies share emerging learning into the review process where relevant.

7.1. Safeguarding Adult Reviews

A Safeguarding Adult Review is held when an adult at risk dies, or experiences serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. The SAR will review the circumstances to see whether any lessons can be learned, and it is important that the learning is shared so that individuals can continue to improve practice. Further information on SARs and other reviews are available on the SSAB website.

7.2. Domestic Abuse Related Death Reviews

Under guidance issued by the Home Office, any incident of domestic violence or abuse which results in the death of the victim requires a review to be carried out by the local Community Safety Partnership.

The purpose of the multi-agency review is to ensure that agencies are responding appropriately to victims of domestic violence and to apply any lessons learned. Further information on Domestic Abuse Related Death Reviews is available on the Salford Community Safety Partnership website.

8. Parallel Processes:

Several other processes may take place alongside an LCSPR, including on-going criminal investigations or coronial process. In most cases parallel processes should not delay the progress of the CSPR and every effort should be taken to avoid any delay in identifying and disseminating learning.

In such cases, it would be the responsibility of the Independent Reviewer (or CSPR Chair if one has been appointed) to liaise with the relevant agency including the Crown Prosecution Service, Police or Coroner to clarify how the CSPR can progress. They must understand what safeguards need to be implemented to not impact or prejudice parallel process. This could include delays in final publication of the CSPR or notification to investigating officers of practitioners involved in reflective practitioner events who may have been/may be police interviewed.

9. Links between Reviews:

A child or their family may be subject of more than one review at a time, and we want to prevent duplication and enhance the impact of learning into practice, so that good practice can be shared across all types of reviews. In these cases, a proportionate approach where agreement about the appropriate lead, and sharing information to save repetition is encouraged.

Where a case meets the criteria for more than one review process, such as a Domestic Abuse Related Death Review or SUDC, or crosses geographic boundaries, a referral should be made to both review processes so that the relevant organisations can work in partnership to identify the most appropriate method to conduct the review, and the possibility of commissioning a review jointly. This will ensure that all aspects of the review are addressed and that the identified process dovetails with any other investigations that are on-going.

For Salford reviews, the Inter-Board protocol will provide a whole system approach whereby communication between the relevant Boards will be through agreed and most appropriate person(s) for that case.

SSCP will share best practice in conducting reviews with other Boards and fora who may undertake thematic reviews but not normally undertake case reviews themselves.

10. Roles and Responsibilities

SSCP Lead Safeguarding Partners	• SSCP Lead Safeguarding Partners delegate responsibility for decision making with regards to the screening panel for rapid reviews to their representatives, who hold appropriate seniority, knowledge, and expertise to facilitate this role. • SSCP Lead Safeguarding Partners do not routinely attend statutory reviews but do have oversight of recommendations, commissioning of reviews and decision making as to whether a CSPR should be published. • The responsibility for how the system and workforce learns the lessons from case reviews lies at a local level with the SSCP and Lead Safeguarding Partners. The SSCP has arrangements in place to ensure that

	serious child safeguarding incidents are identified and reviewed in line with Working Together to Safeguard Children (2023). In Salford this is via the Practice Review Subgroup. • SSCP Lead Safeguarding Partners have the formal authority to request information from agencies to support both national and local Child Safeguarding Practice Reviews
SSCP Screening Panel	• The SSCP screening panel members are key representatives from the Statutory Partners who hold appropriate seniority, knowledge, and expertise to determine the criteria for practice review. • The screening panel will meet within 5 working days of receipt of any referral to determine next steps.
SSCP Business Unit	• SSCP Business Unit is responsible for administrative support and co-ordination of all case reviews. • They are responsible for liaising with the National Child Safeguarding Panel when a Serious Incident Notification has resulted in a decision to initiate a Rapid Review and for updating them of the outcome within the 15 working day timeframe. Delays and exceptions to these timescales must be shared with the National Panel timely. • Published reviews and associated learning briefings will be placed on the SSCP website by the SSCP Business Unit and remain publicly available for one year and then they can be removed.
Independent Scrutineer	• The Independent Scrutineer provides scrutiny of safeguarding practice by partner agencies in Salford. With regards to case reviews, this is done is through the robust oversight of the case review process. This includes decision making of the screening panel whether a referral has met criteria for a Rapid Review and subsequent consideration as to whether a Child Safeguarding Practice Review is required.

Independent Reviewers	• Independent Reviewers are commissioned and appointed by the SSCP to undertake a CSPR. • They are responsible for facilitating enquiry, reviewing and analysing agency information, and engaging with practitioners and families involved in the review. • Methodology applied in any review should be agreed by the CSPR panel and should allow for deeper exploration and robust analysis of the thematic system and practice issues identified during the Rapid Review. The methodology should enable the Independent Reviewer to be professionally curious and provide respectful challenge to agencies around an agreed terms of reference that allows for learning, recommendations, and SMART actions to be developed in a timely manner.
CSPR Panel	• The CSPR panel is made up of strategic agency representatives who are senior enough to make decisions and support the Independent Reviewer in the development of recommendations. There may be occasions when a panel member has had some involvement with the child(ren) or their family. At the planning stage of the CSPR, panel members will be asked if they have any declaration of interests which will be recorded and shared in the minutes for transparency. These should be declared using the SSCP Declaration of Interests Form. • Representatives on the CSPR Panel must also take into consideration the possible conflict of interest which might occur if they are responsible for managing services which are subject to review. These should be declared using the SSCP Declaration of Interests Form. • The Independent Reviewer will share electronic draft versions of reports as the review progresses, with the CSPR panel. These should always be checked for factual accuracy and timely responses provided to agency specific questions. Draft reports must not be forwarded to anyone else without permission of the Independent

	Reviewer and must be deleted at the end of the review process.
Individual agency	• Individual agencies in Salford should have established arrangements in place for identifying incidents where children have suffered serious harm or death. They should also have arrangements in place where they are able to understand any learning that has stemmed from reviews to implement changes to frontline practice. • They should understand if they have a representative on the Practice Review Subgroup or/and have arrangements in place so any frontline professional can discuss a case or incident with their Designated Safeguarding Lead. • Following a request from the SSCP, individual agencies are expected to provide relevant information, in line with good practice principles on information sharing, to support statutory reviews. This should be within requested timescales. This may include engagement, interventions, and interactions with specific children and/or their families who are subject of the review and analysis of safeguarding practice. • Chronologies and agency summaries submitted as part of the review process should be of high quality and have been quality assured by a Designated Safeguarding Lead and/or the agency representative of the Practice Review Subgroup. • Individual agencies should provide adequate support to individual practitioners who may have been directly involved with a child and/or their family, prior to a serious incident. Especially if the professional is aware that a statutory review is taking place as this could result in stress, anxiety, or traumatisation.
Practitioners	• Frontline practitioners are often not included in the panel meetings for statutory reviews; however, they are often invited to contribute in a reflective session to support the Independent Reviewer understand decision making, or they may be asked to

	attend a learning briefing once a review is complete.
Children and Families	• Involvement of the child (ren) subject of the review and their family should always aim to be sought to understand their voice and perspective. • In a CSPR, the stage at which this takes place will be considered specifically by the CSPR panel and Independent Reviewer. Any communication with family members or individuals about the progress of a review will be sensitively managed and a priority for the SSCP Lead Safeguarding Partners
National Child Safeguarding Practice Review Panel	• The National Child Safeguarding Practice Review Panel are responsible for analysing data and information from serious incident notifications and statutory reviews and highlighting recurrent system issues and lessons learned. They publish thematic and annual reports based on these findings, to influence frontline practice to make the safeguarding system more effective. • The Panel meet monthly and provide feedback on the outcome of all Rapid Reviews, including providing guidance to SCPs on whether they agree with local decision making on whether a case has met threshold for a Child Safeguarding Practice Review.
Practice Review Subgroup	• The purpose of the Practice Review Subgroup is to have oversight of all practice reviews (both statutory and non-statutory) undertaken on behalf of the SSCP. • Practice Review Subgroup maintain oversight of action plans and monitor the implementation and recommendations from all types of local reviews, obtaining assurance from agencies that learning is embedded into practice and impacting on outcomes for children. • Learning from reviews is disseminated to practitioners in different ways including 7-minute briefings, inclusion within wider safeguarding training, thematic and targeted learning briefings and annual events. Practice Review Subgroup members

	are asked to ensure that learning is widely disseminated within their agencies. • In the case of any disagreement or failure to comply with a formal information request for a CSPR, the Independent Reviewer will refer the issue to the Practice Review Subgroup who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the SSCP Lead Safeguarding Partners for formal action.
Local Authority	• The local authority must notify the Secretary of State for Education, and Ofsted of the death of a looked after child. The Local Authority should also notify Secretary of State and Ofsted of the death of a care leaver up to and including the age of 24.

11. Information Sharing

If the SSCP requests a person or organisation to supply information to support the review process, they have a duty to comply with that request as detailed within Working Together (2023) statutory guidance.

All agencies who were involved with the subject child or family will be required to contribute to the review. Agencies will need to prioritise information sharing for Rapid Reviews and provide completed initial information within five working days of request.

12. Escalation

Child death review partners may request that a person or organisation provide information to enable or assist the reviewing or analysing of a child's death. The person or organisation must comply with such a request. If they do not comply, the child death review partners may instigate legal action to enforce (s.3.86, Working Together, 2023).

13. Media interest:

All media enquiries regarding CSPRs must be referred to the SSCP Lead Safeguarding Partners via the SSCP Business Unit.

14. Involving Children and Families in Practice Reviews

The lived experience of children and families plays a crucial role in understanding how we can help improve the safeguarding system. Involving children and families in the referral process and any type of practice review is a priority for the partnership. In Salford, we consider it good practice to involve parents and children (subject to age and understanding) in a meaningful way, and reviews should, where appropriate be informed by family members' knowledge and experiences relevant to the period under review. There should be a common understanding amongst the professionals on how children and their

families should be involved, and who should be responsible for facilitating their involvement, recognising that not all information should be shared with the child or family.

The overarching principle should always be to act in the best interests of the child. If it is decided that such involvement is not in the best interests of the child, then the reasons for the decision should be clearly stated in the meeting notes.

The SSCP can support and advise practitioners regarding how this may be best achieved. See Involving Children and Families in Practice Reviews guidance for further information.

15. Chronologies:

There is a strong commitment that robust and proportionate chronologies inform decisions to initiate case reviews and determine the scope and methodology for review. Each relevant agency will provide 'Significant Practice Event' chronologies to detail its involvement with the child who is the subject of the review and the impact on the child's lived experience. Whilst this framework embraces the value of local approaches to chronologies, a robust and consistent approach focussed on the following principles should be considered:

- Risk – each Significant Practice Event (SPE) details the presentation of risk
- Response – agency response is clear
- Impact- How did the agency response impact on the presenting risk and lived experience of the child?
- Partnership – understanding of multi-agency considerations is apparent
- Learning – the core of the methodology and chronologies should identify learning opportunities, particularly those which are significant or new.

The use of Significant Practice Events (SPE) chronologies is integral to ensure clear parameters of any review are agreed based upon the circumstances of the case. They will be used to support decision making on whether Child Safeguarding Practice Review criteria have been satisfied; how case reviews can be discharged in a proportionate way; and how engagement with Case Groups should be configured. Agencies should consider the following when preparing SPE chronologies:

- Is this event one that changed/could have changed your assessment of the situation for the child?
- Is this event symbolic or indicative of a pattern of events that individually would not otherwise be considered significant?
- Is this a 'statutory' event e.g. child protection conference, court hearing or similar?
- Would this have been an event that the child perceived as significant in their life?
- Would this have been an event that a significant adult would perceive as significant in their life or the life of the child?
- Has this event got significance as a learning point for agencies?

16. Securing Files:

Where the severity of a case demands it, all agencies should also secure all records/files in relation to the case, ensuring they are removed to a secure place where they are not accessible to agency personnel other than through a nominated representative. (This request is included in the template letter). Where access to the records is required for on-going case work, a copy should be made and secured.

17. Setting the date of the review meeting:

At the same time as requests for information are sent, the Business Unit should set the date for the review meeting at the appropriate timescale. It is good practice to also ensure there is a time in the Decision Makers' (the three statutory partners and independent advisor) diary after the case discussion meeting to sign off the report and documents to the National Panel.

18. Documentation for the review meeting:

The documentation will be shared with participants at least 24 hours in advance of the meeting wherever possible. However, it is recognised that it may on occasion be necessary to share documentation at the meeting, and in these instances sufficient reading time should be allocated at the beginning of the meeting. Documents to be shared are:

- the completed Referral Form that initiated the process;
- copies of the completed **Agency Summary Form** from relevant agencies.
- Individual agency chronologies will be amalgamated into a composite chronology by the SSCP business unit. It is therefore critical that chronologies are provided in the correct format.

19. The review meeting and decision making:

The meeting should include representatives from each of the three safeguarding partners and any other relevant individuals. A Rapid Review meeting will only be quorate if at least one representative is present from each of the three safeguarding partners (the CCG, Police and Local Authority).

The Rapid Review meeting should:

- review the facts about the case as presented in the documentation
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately
- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide whether or not to undertake a child safeguarding practice review. If the decision is not to proceed with a formal child safeguarding practice review, the Group will consider whether an alternative form of learning review is appropriate. In some cases, the rapid review process may identify key local learning that can be quickly acted upon, removing the need for further review
- consider the impact of any significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances a rapid review can still be completed, not least because it is the multi-agency working which is the key focus (i.e. what happened between agencies *before* the incident.

There are three likely outcomes from the rapid review:

1) Recommendation for a child safeguarding practice review (replacing serious case reviews)

2) Other type of local review or learning event

3) No further action

In all outcomes, any immediate actions and learning should be discussed by the PRSG, acted on and followed up.

The Rapid Review Meeting Report should be completed by the Chair by the deadline (see flowchart). The report should state clearly whether the recommendation is that a Child Safeguarding Practice Review is appropriate, or whether they think the case may raise issues which are complex or of national importance such that a National Review may be appropriate.

The Independent Scrutineer and the three statutory partners endorse the outcome of the Rapid Review. Where there is disagreement about the outcome, the decision will be escalated to the next level within the three partners up to the Safeguarding Executive if necessary for decision. There may be instances where they will need to draw on their own agency legal advisors.

20. Conducting a Local Child Safeguarding Practice Review

20.1. Commencing a review, terms of reference and appointing a Lead Reviewer:

As soon as it has been agreed that a further review is required following the rapid review, the Business Manager will inform the National Panel including details of any reviewer they have commissioned, if known.

The safeguarding partners are responsible for commissioning and supervising reviewers. The Practice Review Virtual Panel will appoint a lead reviewer within 10 working days of decision to commence a fuller review. The lead reviewer does not need to be external to the local area but should meet the minimum criteria in the Review Chair and Lead Reviewer Specification and confirm they have read and will adhere to this practice review policy and have a signed contract in place.

Terms of reference will be drafted at the rapid review meeting stage and be agreed by the review group, for sign off at the next Practice Review Subgroup.

20.2. Conducting the Review:

A **Review Group and Chair** will be established for each Child Safeguarding Practice Review, to oversee the governance of the specific review. The group should be made up of senior managers from relevant agencies and qualified lead reviewers who are independent of the case. They will:

- Agree Terms of Reference which will include timescales for completion
- Determine how the child or family will be involved and informed throughout the review
- Establish what evidence is required from each agency or person and how it will be collected
- Identify relevant policy, practice or procedures that may be relevant to the conduct of the review
- Consider the nature and extent of any legal advice required, including Data Protection, Freedom of Information and Human Rights Act.
- Analyse the evidence to understand why the incident took place. In particular, the Review Group will consider any wider systemic issues.

- Agree key points to be included in the report and action plans and agree the final version of the review report.

The Chairperson will set meeting dates and agendas, ensure relevant representatives are involved and liaise with statutory agencies such as the police and/or coroner's office. They will be supported by the business unit in these tasks.

A **case group** will consist of frontline practitioners and managers who were involved with the case, especially those involved in the significant practice events. Case group members can individually contribute to the case review. The aim is to understand the practitioners' view of events and assist in analysing 'contributory factors' and how the safeguarding system can be improved.

Practice Review Reports- completing and publishing:

All reviews of cases meeting the criteria for a Child Safeguarding Practice Review under the Working Together 2023 criteria will result in a review report. Review reports will vary according to the lead reviewer's style. However, lead reviewers and the SSCP will ensure that all review reports include:

- have clearly framed questions that the review seeks to answer;
- a brief overview of what happened and the key circumstances, background and context of the case. This should be concise but sufficient to understand the context for the learning and recommendations;
- a summary of why relevant decisions by professionals were taken;
- a critique of how agencies worked together and any shortcomings in this;
- whether any shortcomings identified are features of practice in general;
- what would need to be done differently to prevent harm occurring to a child in similar circumstances;
- what needs to happen to ensure that agencies learn from this case.
- have an executive summary of no more than 2 A4 pages;
- state clearly the learning points and the steps for professional learning;
- be written such that the review report can be published nationally with minimal redaction.

The draft report should be sent to contributing agencies inviting comments on the factual accuracy. It is important to note that agencies are not being asked to agree with the report or findings, but to ensure the report is factually accurate, understood and recommendations are clear. Agencies have 10 working days to respond. The Review Group will consider all comments and agree the final version for sign off by the three statutory partners.

The National Panel recommends that all child safeguarding practice reviews and legacy Serious Case Reviews should be published, but there is no statutory requirement to do so. We aim to publish all reports, but they will be considered on a case-by-case basis, and a community impact assessment may be undertaken to assist in this decision.

The SSCP will send copies of all reports to the National Panel at least one week before publication. If the SSCP considers that a review report should not be published, it should inform the Panel which will provide advice to the SSCP.

Publication of review reports will be accessible on the SSCP website for a minimum of 12 months, thereafter the report will be available on request. From the very start of the review, the fact that the report will be published should be taken into consideration, and reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

The findings from any Practice Review will be published in the SSCP Annual Report along with the actions taken in relation to those findings.

20.3. Learning and Improvement:

The multi-agency action plan for reviews should be agreed by the review group and 'handed over' to the business unit to monitor progress, ensuring no unnecessary delay in implementation. The impact of the action plans will be owned and scrutinised by the Practice Subgroup and Safeguarding Effectiveness subgroup. Plans should be outcome focussed and include actions that are needed, responsibilities for completion, timescales and intended outcomes: what will change as a result?

The SSCP will oversee implementation of actions resulting from all reviews, and the Independent Adviser will undertake an annual scrutiny of action plans to review, challenge and support and test impact and learning.

Learning from all types of practice review is imperative. Identifying the correct methods, time that is most effective will be important, and PRSG will work with the Strategic Workforce Development subgroup and Communications and Engagement subgroup to both arrange learning opportunities as well as be assured that individual agencies have implemented and sustained any learning and actions. This may include following up changes to policies and procedures, learning events, using the Practitioner Forum as determining success, views of professionals may need to be gathered.

20.4. Cross Boundary Issues:

There will be cases where children have moved from their 'home' area and may be living outside the area. If this is the case, the review should be carried out by the local safeguarding arrangements that is responsible for the location where the serious incident took place. Multi-agency safeguarding arrangements and agencies should co-operate across boundaries and requests for the provision of information should be responded to as a priority. If agreement cannot be reached on the requirement for the review, the ultimate decision making will be delegated to the Executive Group.

21. Measuring Performance:

We will collect and use the following data to help us monitor and improve the system and impact it has. This will be provided to the SSCP on an annual basis:

How much have we done? • Number of referrals by type, outcome, referrer and theme • Number of reviews by type and outcome • Number of reviews where there is disagreement between SSCP and National Panel
How well have we done it? • Timeliness of reviews • Quality of agency summaries • Quality and timeliness of action plans
Have we made a difference? • Action plans completed and followed up evidence impact • Reflective sessions report greater understanding of the issues

- No repeat incidence in same circumstances following implementation of actions.
- Family members involved report that the review has been conducted in a sensitive way.

Appendix A: TOOLKIT

Document	Type	Purpose
1. Engaging Children and their families in reviews guidance	Guidance	Guidance about involving children and families in reviews.
2. Referral Pathway guidance **and** Referral Form	Guidance Template	Form to make a referral for practice review
3. Good outcome review guidance and referral form	Guidance Template	Encourages professionals to put forward cases where there has been good practice and good outcomes for the child and learning that can be applied.
4. Agency Summary Report	Template	Gather initial information from agencies involved in the case
5. Chronology template	Template	
6. Process for managing declarations of interests	Guidance	Guidance about how declarations of interest will be managed.
7. Declaration of interest form	Template	
8. Practice Review Assurance Questions and checklist	Guidance	Checklist for chairs, lead reviewers and those involved in reviews, including what makes a good review.
9. Case Discussion Tool	Template	Provides a format for structuring practice review discussions
10. Rapid Review Meeting Report	Template	Summarise discussion and findings from rapid review meeting.
11. Review Action Plan	Template	Action plan format for all practice reviews
12. Rapid Review Agenda	Template	Structure for rapid review meeting